DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G027	A. BUILDING _____ B. WING _____	09/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	3215 20TH STREET, NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from September 17, 2007 through September 19, 2007. The survey was initiated using the fundamental survey process. A random sampling of three clients was selected from a residential population of six females with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and two day programs, as well as a review of client and administrative records, including incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that prescribed treatment services were provided timely by the contract pharmacy for one of three clients in the sample. (Client #3) The finding includes: The facility failed to ensure Client #3 was provided prescribed equipment and medication timely for her broncho spasms/asthma. Client #3 was assessed by the pulmonologist on January 31, 2007 for diffuse bilateral wheezing. The pulmonology diagnosed the client with bronchospasm and asthma, and precribed "Duoneb Inhalant Solution, 1 twice a day." A nebulizer was recommended to be ordered through the pharmacy providing services to the	W 120	The Director of Health Services has met with the representatives from the Pharmacy on 04/06/07 and 10/04/07 to ensure that they are able to provide medical equipment to the individuals supported in a timely manner. The pharmacy has provided the Director of Health Services with additional "hot-line" telephone numbers to assist with communication between the two entities and a representative had been assigned to personally handle our account. In the event that medications/equipment does not arrive in a timely manner, the Provider has solicited the services of back-up provider for pharmacy services. The provider will continue to assess the services provided by the pharmacy and make changes as deemed necessary.	10/4/07

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ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director | 10/15/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 group home. Interview with the nursing staff and the record verification on September 19, 2007 at 10:37 AM revealed the following information concerning the procurement of the medication and the nebulizer machine. a) A nursing progress note dated February 5, 2007 at 8:30 AM, revealed the nebulizer had not been delivered to the facility. A second request was was made by telephone and the physician's order was faxed. Next day delivery was promised by the pharmacy. b) Further record review revealed a verbal medical order from the Primary Care Physician (PCP) dated February 7, 2007 which stated the previous order should be discontinued. The verbal physician's order order prescribed "Albuterol Nebulizer treatment 0.83% Q 4 hours prn SOB/Wheeze. Please provide nebulizer machine." c) A nursing progress note dated February 9, 2007 revealed a third request was called to the pharmacy on that date to request the nebulizer. The nurse was informed by the pharmacy representative that the nebulizer had not been sent to the facility because the the first two orders had not been completed. The nurse was then informed that the machine would be provided within four hours. Interview with the nurse on September 19, 2007 revealed the pharmacy provided the nebulizer to the client until February 9, 2007.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client,	W 124		

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W 124	Continued From page 2 parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a system was established to obtain consent for treatments that may cause risks to the rights of one of three clients in the sample. (Client #3) The finding includes: 1. [Cross refer to W322,5]. Interview with the Registered Nurse (RN) and the Qualified Mental Retardation Professional (QMRP) on September 19, 2007 at 12:19 PM revealed a colonoscopy recommended for Client #3 had not been completed. Record review also revealed the colonoscopy was recommended during a May 24, 2006 GI consultation. Interview with the QMRP on September 19, 2007 revealed affidavits had been forwarded to Developmental Disability Services and the case manager for further action toward guardianship. Interview with the nurse and the QMRP also indicated the procedure was deferred due to the lack of a legally authorized representative to sign the consents. At the time of the survey, there was no evidence a guardian/surrogate decision maker had been obtained timely for the completion of procedures recommended to monitor the client's health. [Note: Record review revealed an unsigned consent form dated January 18, 2006 for a colonoscopy. The client was not seen due to not	W 124	Paperwork to obtain a legal guardian for client #3 was submitted in May of 2007 and the QMRP made several follow up calls to the case manager to inquire about its status. The QMRP was told that the paper work had been submitted and was "being processed". MOP will follow up with the new supervisor of case management at DDS to insure that either a permanent or temporary guardian is appointed so that the cited follow up consultations can be scheduled as soon as possible and implemented.....10-31-07. The QMRP will seek the assistance of the Quality Trust if further delays are encountered in obtaining the needed guardian. In addition, MOP QMRPs and others will attend the upcoming training on guardianship sponsored by DDS so as to have the most current information about the process and procedures. See response to W322.5	10/30/07

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W 124	Continued From page 3 having the consent of a surrogate decision maker.] 2. [Cross refer to W212]. Record review revealed that during a neurology consultation on September 7, 2006, the neurologist provided a written referral for the client to be evaluated to rule out seizure activity and dementia. Additionally, the record review revealed a prescription for an MRI with and without contrast scheduled to be performed on September 25, 2006. The consultation reports dated September 25, 2006 and March 6, 2007 revealed that the client would not hold her head still and follow instructions to have the MRI performed. The radiologist recommended that the client be sedated to complete the procedure. Interview with the RN and the QMRP on September 19, 2007 at 12:05 PM revealed that the MRI with and without contrast was deferred because the client did not have an legally authorized representative to give written consent for the sedation. At the time of the survey, there was no evidence MRI was completed as recommended to rule out seizure activity and dementia.	W 124		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensured the health and safety of five of the six	W 149	The RN and the QMRP will review the Health Management Care Plans for each person supported to insure that all safety concerns are addressed by clear strategies outlined for staff in protocols by the relevant discipline. Updates and/or modifications will be completed as needed and staff will be trained on any such modifications. This process will be completed by...10-30-07.	10/30/07

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W 149	Continued From page 4 clients (Clients #1 and #4) residing in the facility. The findings include: 1. The facility failed to ensure an effective system to prevent Client #1's from injury as detailed below: Client #1 was observed through out the survey (September 17, 18, and 19, 2007) ambulating short distances using rolling walker with a seat. Staff was observed consistently providing arm distance supervision while the client ambulated with the walker. The review of unusual incidents on September 17, 2007 at 3:20 PM revealed that Client #1 had a history of injuries from falls and during transfers. a)The review of an ER report dated 5/10/07 revealed the client sustained an injury to her face and was treated at the hospital for a contusion on forehead and abrasion to head/scalp. The review of a nursing progress note dated 5/10/07 revealed at 6:00 PM a call was received from the residential manager indicating the client fell outside and sustained several abrasions to her face. Staff were advised to take the client to the ER for evaluation. b) The review of an unusual incident report dated 7/3/07 revealed at 7:30 PM Client #1 became unsteady on her feet while walking from the dining room to the living room. As she attempted to sit on her walker seat, she lost her balance and fell on her left arm and hand. She sustained a 2 inch bruise above her pinkie ring finger. The client complained of pain and a cool compress was applied. The review of the investigative summary indicated the client became	W 149	See Response to W436 See Response to W153 The QMRP, Residence Manager & RN will separately conduct on site monitoring at minimum weekly to ensure they are aware of and respond to any health/safety concerns discovered. In addition, the QMRP and RN will meet monthly to discuss all health care concerns for each person supported in order to insure that timely follow up is implemented for all such concerns.	10/30/07

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W 149	Continued From page 5 unbalanced after turning suddenly to sit on the walker seat, missed the seat and leaned against the walker. She was unable to steady herself. Observation and inspection of Client #1 rolling walker on September 19, 2007 at 8:15 AM determined that left hand brake would not lock the left wheel in place. The unlocked brake allowed the walker to continue to move on the left side when pushed. [See W436] c) The review of an incident summary dated July 8, 2007 revealed two staff were assisting the Client #1 into bed when the client lost her balance again tilting to the right. Staff attempted to hold the client up. She was "dead weight" and her head came into contact with the exit door and she bumped the right side of her forehead on the corner of the door panel. The client had some swelling and scrape to the area. d) The review of an unusual incident report dated July 7, 2007 revealed at approximately 8:05 PM, two staff putting Client #1 in her bed noticed her right jaw to have a bruise and to be swollen. The QMRP and the residential manager were notified. The nursing assessment dated July 7, 2007 indicated the client verbalized pain in her right jaw. The client was treated with cold compresses and Tylenol. Although the facility's internal investigation could not determine the origin of the injury, the investigation (dated July 9, 2007) revealed the client began to have difficulty during ambulation after an increase in her seizure medication (Trileptal) on June 25, 2007. The facility's investigation also revealed that prior to the discovery of the injury, the client was observed	W 149		

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W 149	Continued From page 6 napping at the table and rocking her head back and forth. She was later found with her head lying on the table and her coffee cup partially turned over. e) Also see W153. 2. The facility failed to implement effective measure to minimize Client #4's risk of injury related to falls as detailed below: On each day of the survey (September 17, 18, and 19, 2007) Client #4 was observed talking as she ambulated independently, with her toes pointing inward, taking short quick steps. Staff was observed telling her to slow down. The review of unusual incidents revealed the client sustained falls on the following dates: a) 3/13/07 - After returning from her day program in the afternoon, Client #4 was walking toward the house fussing, intermittently looking back toward the van. About halfway down the driveway, her legs crossed over one another and she fell to the ground, scraping her nose, the knuckles of three fingers on her left hand. The review of the incident addendum written by the QMRP dated 3/14/07 revealed the client failed to calm down after continuous prompts from the direct care staff. Further review of the incident addendum indicated the fall appeared to have occurred due to the client ' s lack of focus while walking. According to the addendum, staff should continue to monitor the client when walking on uneven surfaces and follow the proactive protocol to be implemented when she becomes frustrated and agitated. If she appears to not be focused while	W 149		

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W 149	Continued From page 7 walking, staff should, " prompt her to calm down and if necessary have her stop walking " until her balance becomes steady and she is more focused. b) 3/27/07 (10:45 AM) -While walking to the doctor's office fussing about her appointment, Client #4 was moving too fast and appeared to trip over her own feet. She fell more on her right side. The Qualified Mental Retardation Professional's (QMRP) investigative summary concluded the ambulation safety protocol was implemented. c) 4/26/07 (12:30 PM) - According to the nursing progress note, Client #4 fell on her hands and knees while walking. The nurse observed that the client was wearing her leg brace at the time of the fall. The nurse's assessment of vital signs and for pain at that time revealed no injury. d) 9/1/07 (12:15 PM) Client fell as she crossed over the threshold of the front door. "It appeared that she may have lost her balance." She was assisted to her feet. Assessments for bruising, discomfort by the nurse were negative. The QMRP addendum indicated that the staff should continue to assist the client when entering the house and remind her to stay focused and avoid fussing when walking. e) 9/15/07- At 3:30 PM fall Client #4 stumbled and fell on the right side to the pavement at the front of the facility while the van was being unloaded. Sustained scratch on chin and elbow. The nurse's assessment at 7:15 PM determined the client to have a 1 cm elbow abrasion and a 1/2 cm chin abrasion.	W 149		

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W 149	Continued From page 8 The QMRP ' s investigative summary revealed the client became impatient and without warning stepped over the side of the ramp, even though staff gave several verbal prompts for her to wait. The addendum to the incident revealed the fall occurred because the client lacked the patience to wait for other and failed to adhere to staff prompts to wait for assistance. Further review of the addendum revealed the correct steps appeared to have been taken in an attempt to prevent the incident. According to the nursing care plan dated 9/18/07, when the client is walking staff should observe gait and provide opportunities to stop and rest or if necessary. Additionally, staff should provide support to the client if her ambulation appears unsteady, if she is walking on uneven terrain or has any diminished walking ability.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures for Client #1.	W 153	1. The injury described here is not an injury of unknown origin. Upon closer review, the nurse determined that bruise to the side of the knee was a blood vessel issue not a trauma issue. This was reported to the QMRP by the nurse but neither documented that in the record. The QMRP and the nurse will insure that such information is documented in the future. The blood vessel issue leaves a long term "bruise" but is non problematic for the future.	10/20/07

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W 153	Continued From page 9 The findings include: 1. The review of an nursing progress note date June 4, 2007 at 8:00 AM revealed the direct care staff reported a bruise around Client #1's right knee, which was more on the side of the knee than on the knee cap. The nurse's observation revealed a medium sized bruise which was blue in color. Reportedly, the client could not remember if she fell. Record review revealed no evidence that and incident report was completed regarding the client's bruise. There was no evidence the client's injury of unknown origin was reported to the facility's administrator or to DOH. 2. The review of Client #1's nursing progress notes revealed that the client was assessed and treated for bruises on the following dates which were not reported to the administrator or DOH as required: a) 1/28/07 - Staff observed a 6 cm by 2 cm wide bruise on the clients lower back. On assessment, facial grimacing was noted with body movement and client answered yes to pain. Tylenol 650 mg was administered. b) 4/22/07 - Staff observed a 4 cm by 2 cm wide bruise on the client's back during ADL care. The client denied pain.	W 153	2. The back bruises noted in "a" and "b" are also not of unknown origin. They were caused by a "flopping" behavior exhibited during bathing. On both occasions, client #1 flopped when getting out of the tub and hit her back on the faucet. To address the issue, a shower chair was added so she would no longer sit in the tub and a grab bar was added to help her with standing balance and transferring. The faucet was removed in favor of a shower head. In addition, she receives one-to-one staff support during showers. The specifics, including all of the follow up steps were not outlined in the QMRP or nursing notes. The QMRP will insure that notes reflect all such particulars in the future. In addition, the QMRP and nursing will meet monthly to comprehensively review all health concerns. Further staff training re: progress note contents & appropriately completing incident reports will be conducted by 10/30/07. Data and Progress notes will continue to be reviewed by the QMRP weekly.	10/15/07
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by:	W 159	It should be noted that in one case (a) there was a bruise but no evidence of pain and in the other (b) there was some pain the initial day for which Tylenol was given and no further evidence of pain thereafter.	10/30/07

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W 159	Continued From page 10 Based on observation, interview and record verification, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6. [See W436] The findings include: 1. The QMRP failed to ensure staff received timely and effective training on interventions to minimize Clients #1 and #4 risk of falls [See W149] 2. The QMRP failed to ensure staff receive effective training on monitoring and reporting malfunctioning assistive devices for Clients #1, #2, #3, #4, #5 and #6. [See W436]	W 159	1. The QMRP will insure that all staff receives further training on all of the issues related to potential falls for clients #1 and #4. The follow up training will occur by...10-30-07. Follow up training in this area will occur during in-home orientations for new staff and will be done at minimum twice annually for incumbent staff. See Response to W149 2. The QMRP will develop a checklist for the purpose of auditing the condition of all adaptive equipment in the home. She will then audit the equipment personally on a monthly basis...10-20-07.	10/30/07
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record, the facility failed to ensure continuing training was provided to each employee to enable them to perform duties effectively and competently for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The findings include: 1. The facility failed to ensure staff training was effective trained on interventions to minimize the	W 189	The staff will be trained on the use of the audit tool and will audit weekly as assigned and report any issues found to the QMRP immediately for appropriate follow up...10-30-07. See Response W153 above. See Response W149 See Response W436	10/30/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G027	A. BUILDING _____ B. WING _____	09/19/2007

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MY OWN PLACE	3215 20TH STREET, NE WASHINGTON, DC 20018

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W 189	Continued From page 11 risk of falls for Clients #1 and #4. [See W149] 2. The facility failed to ensure staff received effective training on reporting of malfunctioning adaptive equipment for Clients #1, #2, #3, #4, #5 and #6. [See W436]	W 189		
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a comprehensive assessment to rule out seizure activity and dementia for one of three clients in the sample. (Client #3) The finding includes: Further record review revealed that during a neurology consultation on September 7, 2006, the neurologist provided a written referral for the client to be evaluated to rule out seizure activity and dementia. Additionally, the record review revealed a prescription for an MRI with and without contrast to be performed on September 25, 2006. The consultation report revealed that the client would not hold her head still to have the MRI performed. The radiologist recommended that the client be sedated to complete the procedure. The review of unusual incidents on September 17, 2007 revealed Client #3 was transferred to the hospital on October 20, 2006 via 911 due to an sudden episode of syncope and lethargy while eating. She was admitted to the hospital where	W 212	See responses for W124	10/31/07

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W 212	Continued From page 12 she remained for treatment until October 23, 2006. The medical record review revealed the client also went for the MRI again on February 27, 2007 however the procedure was rescheduled due to arriving late. A radiology consultation report dated March 6, 2007 revealed "Patient can't have MRI of brain. She can't hold still nor follow instructions." Interview with the RN and the QMRP on September 19, 2007 at 12:05 PM revealed that the MRI with and without contrast were deferred because the client did not have an legally authorized representative to give written consent for the sedation. There was no evidence MRI was completed as recommended to rule out seizure activity and dementia.	W 212	1. Client #2 will be scheduled for ENT follow up by 10/18/07. Subsequent to the ENT appointment Client #2 will be rescheduled for an audio evaluation. RN, QMRP & Residence manager will continue to meet monthly and schedule all needed appointments at that time.	10/18/07
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide preventive and general medical care for four of the six clients residing in the facility. (Client #1, #2, #3 and #4) The findings include: 1. The facility failed to ensure that Client #2 was provided an Speech and hearing evaluation as recommended. Record review revealed Client #2 had a	W 322	2. The RN supported by the Director of Health Services will follow and document all acute issues like the nebulizer issue on a daily basis until they are resolved. The Director of Health Services will ensure that physician services are coordinated between the Primary Care Physician and specialist providers to ensure prompt follow through of orders. Additional staff training will be completed and provided by 11/01/07 to require that staff immediately report the failure of ordered medications/equipment to arrive at the home. The Director of Health Services will provide nursing staff with additional training to reiterate the importance of coordinating with insurance providers to obtain non-formulary medications and/or equipment to ensure outside services to meet the need of the individuals supported.	11/1/07

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W 322	Continued From page 13 scheduled speech and hearing consultation on June 30, 2006. The specialist stated the assessment could not be completed due to the client's bilateral cerumen occlusion of her ears. At that time it was recommended that the client return to the speech and hearing clinic for evaluation after the cerumen occlusion had been removed. Interview with the RN on September 19, 2007 at 11:52 AM revealed the client's wax occlusion had been not been removed. Interview with the QMRP revealed that a new ENT specialist had been selected to provide services to the facility. Record verification revealed the last ENT visit was dated March 28, 2007. 2. The facility failed to ensure Client #3 received nebulizer treatments timely to address her pulmonary condition. Client #3 was assessed by the pulmonologist on January 31, 2007 for diffuse bilateral wheezing. The pulmonologist diagnosed the client with bronchospasm and asthma and prescribed "Duoneb Inhalant Solution, 1, twice a day." The nebulizer was recommended to be ordered through the pharmacy providing services to the group home. Interview with the nursing staff and the record verification on September 19, 2007 revealed the following information concerning the procurement of the medication and the nebulizer machine: a) A nursing progress note dated February 5, 2007 at 8:30 AM, revealed the nebulizer had not been delivered to the facility. A second request was was made by telephone and the physician's order was faxed. Next day delivery was promised by the pharmacy.	W 322		

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W 322	Continued From page 14 b) Further record verification revealed a verbal order from the primary care physician (PCP) dated February 7, 2007 was to discontinue "Duoneb Inhalant Solution, 1, twice a day" with a new verbal order for "Albuterol Nebulizer treatment 0.83% Q 4 hours prn SOB/Wheeze. Please provide nebulizer machine." c) A nursing progress note dated February 9, 2007 revealed a third request was called to the pharmacy on that date to request the nebulizer. The nurse was informed by the pharmacy representative that the nebulizer had not been sent to the facility because the the first two orders had not been completed. The nurse was then informed that the machine would be provided within four hours. d) Interview with the facility's nursing director on September 19, 2007 revealed the Duoneb Inhalant Solution that was originally o prescribed by the Pulmonologist was not covered by the client's insurance company. Initially the pulmonologist did not want to change the medication to any of the other medications recommended by the pharmacy. However, the nursing director stated that the pulmonologist, the PCP and the pharmacist came to a consensus on February 7, 2007 to prescribe Albuterol as a substitute. Further interview with the nurse revealed the client received the Albuterol nebulizer on February 9 2007. There was no evidence the client received timely treatment services to address her bronchospasms and asthma. 3. The facility failed to ensure that Client #3 received a timely Brain MRI as recommended. [See W212]	W 322	3. See Response to W124	10/30/07

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W 322	Continued From page 15 4. The facility failed to ensure that Client #3 received a timely colonoscopy as recommended to rule out GI neoplasm. Interview with the RN and the QMRP revealed the colonoscopy had been deferred until an authorized representative could be obtained consented for the procedure. According to a nursing progress notes, dated March 5, 2007, the client needed the colonoscopy screening for constipation and blood in stool. The review of the QMRP quarterly review completed for the period April 25, 2007 through July 25, 2007 revealed the colonoscopy was recommended during the May 24, 2006 GI consultation. Interview with the QMRP on September 19, 2007 at 12:19 PM revealed the affadavits had been forwarded to the Disability Services and the case manager for further action toward guardianship. At the time of the survey, the colonoscopy had not been performed.	W 322	See response to W124	10/30/07
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that nursing services were provided in accordance with the assessed needs for two of the six clients residing in the facility. (Clients 1#, #3 and #6) The finding includes:	W 331	See response to W369 See response to W382	10/31/07

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W 331	Continued From page 16 1. The facility failed to establish a system to ensure that all medications were administered without error for Client #3. [See W369] 2. The facility's medication nurse failed to ensure that the medications in the storage closet were supervised at all time during the administration Client #6's prescribed treatment in her bedroom. [See W382]	W 331		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish a system to ensure that all medications were administered without error for one of three clients in the sample. (Client #3) The finding includes: 1. The facility failed to establish an effective system to ensure that Client #3 took her medication for insomnia at the prescribed hour as follows: On September 17, 2007 at 6:50 PM, Client #3 was observed being administered Melatonin 1 mg, 1/2 tab (.5 mg) by the medication nurse. Interview with the nurse revealed the medication was prescribed to help the client sleep better at night. The review of the medication administration record (MAR) and the physician's orders a 7:37 PM revealed the medication is prescribed for insomnia and should be	W 369	The Director of Health Services will ensure that medications are administered at the prescribed hour. Client #3 routinely goes to bed between 9p-11p. The Director of Health Services and QMRP will ensure that a Trained Medication Employee (TME) is available to administer medications at bedtime.	10/15/07

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W 369	Continued From page 17 administered at bedtime. The review of the client psychological assessment dated 4/2/07 indicated the client is prescribed a sleeping pill to prevent her night time terrors and hallucinatory experiences. Interview with staff on 9/17/07 at 8:15 PM revealed the client would relax after dinner, then be prepared for bed. The review of the client's activity schedule indicated she should be asleep between the hours of 10:00 PM and 6:00 AM. There was no evidence Client #3 received her medication at bedtime as prescribed. [See also W489]	W 369		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility's medication nurse failed to ensure that medications were supervised at all time during medication administration for one of six residents residing in the facility. (Client #6) The finding includes: On September 17, 2007 at 7:09 PM, the medication closet was observed unlocked. The nurse left the office, where the medication closet was located, to administer a treatment to Client #6. The medication closet remained unlocked and unsupervised until 7:15 PM. The nurse was interview and acknowledged that all medications should have been locked except when being	W 382	The Director of Health Services will ensure all nurses receive additional training on medication administration protocols and safety measures by 10/31/07. In addition the delegating nurse will perform random medication pass observations to assess if Agency policies and procedures for medication administration are being adhered to. Failure to follow these procedures will result in disciplinary action.	10/31/07

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W 382	Continued From page 18 prepared for administration.	W 382		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure devices and aids identified by the interdisciplinary team as needed by the client were maintained in good repair for six of six clients residing in the facility. (Client #1, #2, #3, #4, #5 and #6) The findings include: 1. The facility failed to ensure Client #1's rolling walker with seat was maintained in good repair. Client #1 was observed using a rolling walker when she ambulated about in the group home and also whenever she left the facility. On September 19, 2007 at 8:15 AM, the left hand brake on Client #1's rolling walker (with seat) would not lock the left wheel in place. The unlocked brake allowed the walker to continue to move on the left side when pushed. Interview with the QMRP on September 19, 2007 at 6:30 PM revealed she was not informed that the brake on the client's walker was not functioning properly. The review of the individual support plan dated August 8, 2007 revealed the walker was recommended for use during ambulation due to	W 436	1. Client #1's rolling walker has been repaired and reviewed by the PT who indicated it is now in good repair.....10-5-07. 2. The PT came out to assess the situation with client #3's wheelchair seatbelt on 10-5-07. He determined that client #3's seatbelt works in that it secures her but as observed by the surveyor, it is frayed. He recommended that it be replaced. MOP will insure it is replaced by.....10-20-07. 2b. The right brake on client #3's wheelchair was checked by the PT during his 10-5-07 visit. The lock works. Staff failed to pull it back completely to lock it in place. The PT informed/instructed the staff on duty that day on properly securing the brakes and will do follow up training with all staff by...10-30-07. 2c. PT stated on 10-5-07, that the foot rest straps were not needed and should be removed. They will be removed by...10-12-07. The left footrest will be repaired by...10-30-07. 3. The toilet seat will be replaced by...10-20-07.	10/5/07 10/20/07 10/30/07 10/30/07 10/20/07

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W 436	Continued From page 19 the client's unsteady gait and risk for falls. 2. The facility failed to ensure Client #3's wheelchair was maintained in good repair. a) On September 17, 2007 at 8:23 AM, Client #3 was observed seated in her wheelchair while being transported to the van. Observation of the wheelchair belt (waist restraint) revealed the right end of the seatbelt was short and very frayed, causing it to be not be properly secured to the clasp. Interview with staff revealed the client uses the wheelchair for mobility when outside the group home due to her severe arthritis and ambulation difficulty. The review of the client's individual support plan dated April 25, 2007 revealed an interdisciplinary team recommendation for the continued of the wheelchair for mobility. b) On September 19, 2007 at 8:25 AM, staff was observed assisting Client #3 into her wheelchair from her walker. The right brake on the wheelchair was observed to not engage against to wheel to lock it in place. This allowed the wheelchair to move backward when staff attempted to seat the client in it. Interview with the QMRP on September 19, 2007 at 6:30 PM revealed she was not informed about the brake on the client's walker. c) Further observation of Client#3's wheelchair on September 19, 2007 at 8:25 AM revealed the left footrest would not remain in an upright position. Additionally, both heel straps were observed to be detached on one side causing them to drag on the ground. Interview with the QMRP indicated that heel straps were not attached when the client	W 436	The QMRP and Residence Manager will routinely check adaptive equipment as per W159. Direct Care Staff will continue to notify the QMRP or Residence Manager when adaptive equipment repair issues are discovered.	10/30/07

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W 436	Continued From page 20 received the chair. 3. The facility failed to ensure the built-up toilet seats in the bathrooms were maintained in good repair. Observation of the toilet seats in the half bath room and the bathroom located off the hallway on September 19, 2007 beginning at 3:20 PM, revealed they lacked a device to securely attach them to the commode. Interview with the Qualified Mental retardation Professional during the environmental inspection on September 19, 2007 at 3:30 PM revealed the devices needed to secure the toilet seats tightly to the commodes were broken. Further interview with the QMRP revealed the elevated toilet seats were used by all of the residents.	W 436		
W 489	483.480(d)(5) DINING AREAS AND SERVICE The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure Client #3 sat in an upright position while eating her meal, unless otherwise specified by the interdisciplinary team or a physician. The finding includes: On September 17, 2007 at 7:50 PM, Client #3's regular plate was observed placed on an elevated block which was approximately two inches tall. At 7:52 PM, she was observed eating independently	W 489	The speech pathologist developed the existing feeding protocol that accepts client number 3's preferred method of eating. The speech pathologist sees no special risks associated with her eating this way but will observe her once again and reassess the situation by...10-20-07. The speech Pathologist will continue to assess feeding skills as per parameter outlined in the assessments.	10/20/07

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W 489	Continued From page 21 using a fork as staff verbally prompted her to continue eating. She was observed still slowly feeding herself at 7:55 PM. At 8:00 PM, the client said she was tired and was observed experiencing difficulty getting the mixed vegetables onto her fork. At 8:05 PM, the client was observed with her mouth down to the edge of the plate and raking the mixed vegetables into her mouth. Interview with the QMRP on September 17, 2007 and the record verification on September 18, 2007 revealed the client is provided a choice of utensil with which to eat her meals (regular or built-up handle). Interview with staff indicated the client's self feeding skills may vary from time to time depending on her arthritis, however she is encouraged to feed herself as much as possible to maintain her independence. The QMRP also indicated that the client's intake may also depend on her food preferences. The review of an occupational therapy assessment dated April 15, 2007 revealed the client does not present with any spillage during meals as she will position her face close to her plate at times to slide the food directly into her mouth. This occurs most often with foods such as rice, peas and other items which tend to move around the plate. There was no evidence the client was prompted to eat in an upright position when sliding the food into her mouth from the plate or that she had been medically approved to eat in this manner.	W 489		

817 Varnum Street, NE Suite 132 Washington, DC 20017 · 202-636-2985 · Fax: 202-526-7572
Kim Scott-Hopkins, Executive Director

October 15, 2007

Sheila Pannell
Acting Program Manager
Health Care Administration and
Licensing Administration
825 N. Capitol Street, NE 2nd Floor
Washington, D.C. 20002

Re: 3215 20th Street, NE

Dear Ms. Pannell:

Enclosed please find the plan of correction, which addresses the concerns noted during the September 19, 2007 survey conducted at our Intermediate Care Facilities for Mentally Retarded (ICF/MR) located at 3215 20th Street, NE.

We have addressed the concerns identified to maintain compliance with the regulatory requirements. Please note that the administration will continue to monitor this home to ensure that the individuals receive quality supports and maintain continual compliance.

If you need additional information, please let me know.

Sincerely,

Kim Scott-Hopkins
Executive Director